STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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§1. General. The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

2. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

3. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

§2. Services which are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency [~~room~~] physicians shall continue to be noncovered as a component of payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

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3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

2. Outpatient hospital services excluding laboratory

a. Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with the Code of Virginia, Chapter 10, Title 32.1, §§32.1-323 et seq.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

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"Recent injury" means an injury which has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for non-emergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, rendered in emergency departments which DMAS determines were non-emergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for (2) above. Services not meeting certain criteria shall be paid under the methodology of (1) above. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilipticus, or other conditions considered life-threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

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(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

3. Rural health clinic services provided by rural health clinics or other Federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§329, 330, and 340.

4. Rehabilitation agencies. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

5. Comprehensive outpatient rehabilitation facilities.

6. Rehabilitation hospital outpatient services.

§6. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the State agency fee schedule (Supplement 4 has information about the State agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services (Supplement 1 has obstetric/pediatric fees). Payment for physician services shall be the lower of the State agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

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"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with the Code of Virginia, Chapter 10, Title 32.1, §§32.1-323 et seq.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury which has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for non-emergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, rendered in emergency departments which DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for (ii) above. Services not meeting certain criteria shall be paid under the methodology of (i) above. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: Community mental health services; Services of a licensed clinical psychologist; Mental health services provided by a physician

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

c. Services provided by licensed professional counselors shall be reimbursed at 70% of the reimbursement rate for licensed clinical psychologists.

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4. Podiatry.
5. Nurse-midwife services.

6. Durable medical equipment.

   a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to 7/1/96 less 4.5% or the actual charge.

   b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

7. Local health services, including services paid to local school districts.

8. Laboratory services (Other than inpatient hospital).

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-Ray services.

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11. Optometry services
12. Medical supplies and equipment
13. Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3.
14. Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients.
15. Clinic services, as defined under 42 CFR 440.90

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII and take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

C. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331(c) if the brand cost is greater than the HCFA upper limit or VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

1. The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§447.331 and 447.332, as determined by the HCFA Upper Limit List plus a dispensing fee. If the agency provides payment for any drug on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The Virginia Maximum Allowable Cost (VMAC) established by the Agency plus a dispensing fee for multiple source drugs listed on the VVF;

3. The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the following methodology set out in (a) - (c) below.

   a. Percent discount shall be determined by a statewide survey of providers' acquisition cost.

   b. The survey shall reflect statistical analysis of actual provider purchase invoices.

   c. The agency will conduct surveys at intervals deemed necessary by DMAS.

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4. Reserved

5. The providers' usual and customary charge to the public, as identified by the claim.

6. Payment for pharmacy services will be as described above; however, payments for drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the Department to have unique dispensing requirements.

7. The Program pays additional reimbursement for the 24-hour unit dose delivery system of dispensing drugs. This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the State Agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the State Agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the State Agency.

8. Determination of EAC was the result of an analysis of FY'89 paid claims date of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9% was determined to represent prices currently paid by providers effective 10-1-90.

   The same methodology used to determine AWP minus 9% was utilized to determine a dispensing fee of $4.40 per prescription as of 10-1-90. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of 7-1-95, the Estimated Acquisition Cost will be AWP minus 9% and dispensing fee will be $4.25.

D. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

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E. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

F. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer Drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation agreements	Rate set by the single state agency
Special emergency transportation	Rate set by the single state agency

G. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

H. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

I. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: State Agency fee schedule, Actual Charge, or Medicare (Title XVIII) allowances.

J. Targeted case management for high-risk pregnant women and infants up to age 2 and for community mental health and mental retardation services shall be reimbursed at the lowest of: State Agency fee schedule, Actual Charge, or Medicare (Title XVIII) allowances.

12 VAC 30-80-111.

K. Foster Care (FC) Case Management. The Medicaid agency will reimburse providers for the covered services for FC case management for each eligible child at the daily rate agreed upon between the local Community Policy and Management Team (CPMT) in the locality which is responsible for the child's care and the FC case management provider. This daily rate shall be based upon the intensity of the case management needed by the child and be subject to an upper limit set by the Medicaid agency. DMAS shall pay the lesser of the rate negotiated by the CPMT or the maximum rate established by the Department.